HEALTHY CONNECTIONS (HC)

1.5.3 Participant Enrollment

Enrollment in Healthy Connections (HC) is prospective and always begins the first day of the month. Each enrolled participant is sent a written notice advising of the name, phone number, and address of their Primary Care Provider (PCP). This notice is sent prior to the effective date of the HC enrollment.

Medicaid participants may choose a PCP in one of the following ways:

1. Indicate their choice of PCP on the Application for Assistance when they apply for Medicaid.

2. Complete and return a HC Enrollment form received in the mail from the Department of Health and Welfare (DHW).

3. Complete a HC Enrollment form at the PCP's clinic who then sends the form to the Regional HC Office.

4. Call the Regional HC Office to enroll over the phone.

Family members are not required to choose the same PCP. If a participant requires assistance in choosing a PCP, the Regional Health Resource Coordinator (HRC) can provide information regarding available PCPs and will assist the participant in making a selection.

Enrollment in HC is mandatory for most Medicaid participants. Exemptions from enrollment are described in *Appendix A, Healthy Connections*. When a Medicaid participant does not choose a PCP and the participant lives in a mandatory participation area, DHW assigns the participant to a HC PCP.

Participants may request a change in their PCP. If the HRC is notified by the twentieth of any month, the change will be effective the first day of the following month. Otherwise, the change is not effective for another month.

Additional enrollment information can be found in *Appendix A, Healthy Connections.*

1.5.4 Referrals

1.5.4.1 Overview

If the HC PCP determines that specialized services are necessary, the PCP refers the participant to a specialist for the services. Medicaid will pay for covered services received from another Idaho Medicaid provider with a referral from the HC PCP. All services requiring a HC referral that are rendered without a referral are considered non-covered services and will not be paid by the Medicaid program.

Prior to performing any services, all Medicaid providers should check to see if the participant is Medicaid eligible and if they are enrolled in HC. When obtaining eligibility information, the provider should also request the name and telephone number of the HC PCP in order to obtain the appropriate referral to provide services. If no HC PCP is listed, no HC referral is needed.

- All services require a referral except for those listed in, *Section 1.5.4.3 Documentation of Referrals.*

- All services requiring a PCP referral that are provided without a referral are considered non-covered services. A provider rendering non-covered services must advise the participant (preferably in writing) prior to providing such services.

1.5.4.2 Method of Referral

A referral is a doctor's order for services. HC PCPs can make a referral for a participant by:

- Filling out a referral form and giving it to the participant (to take with them to the specialist) or send it directly to the specialist.
- Ordering services on a prescription pad.
- Calling orders to the specialist.

1.5.4.3 Documentation of Referrals

Both the PCP and the provider being referred to must document the specifics of the referral in the participant's file. If the PCP has completed a referral form, a copy of the form should reside in the participant's file in both providers' offices. If another form of physician order or referral was used, such as a phone call or standing order, this information is also required to be in the participant's files and should include specifics of the referral or physician order.

Use of a PCP's HC referral number indicates that the billing provider has obtained and documented the referral in the participant's record.

Note: Using a referral number without obtaining a referral is fraudulent**.**

The details of the referral are to be documented in the participant's permanent record by both the referring provider and the provider to whom the referral was made. The record should include:

- Who made the referral.
- Date of referral.
- Scope of services to be provided (including authorization for the receiving providers to use the PCP's referral number to refer the participant to additional, related ancillary services).
- Referral number (for billing purposes).
- Duration of the referral.

1.5.4.4 Scope of Services Authorized

The scope of services authorized by a referral is determined by the PCP and defines the limitations of the referral. The following are examples:

- Number of visits authorized (i.e., ten physical therapy visits).
- Time limited (i.e., treat for three months).
- Diagnosis or condition related (i.e., treat for developmental delay).

Questions regarding the scope of a referral should be directed to the PCP.

If a HC PCP routinely refers a participant to one specialty provider such as lab, radiology, etc., the PCP can authorize a standing order. A standing order is subject to the same information and documentation requirements as any other referral. The maximum duration of a HC referral or standing order is one year.

A HC PCP may authorize the specialist receiving a referral to order additional services on behalf of the PCP. For example, a referral to diagnose and treat authorizes the specialist to order tests (i.e., lab, x-ray, etc.) to accomplish diagnosis. In these cases, the specialist is to forward the referral information (including the referral number) to the appropriate service providers.

Developmental disabilities and mental health services delivered under a plan of care also require a referral from the PCP, in addition to any other program prior authorization (PA) requirements. The services must be a covered benefit of the participant's benefit plan. DHW staff or designated

delegates overseeing service delivery are authorized to forward appropriate referral information to the various providers for service indicated in the approved plan of care.

Specialists or providers who receive HC PCP referrals are to report findings/progress back to the PCP unless the PCP indicates they do not want to receive such feedback.

1.5.4.5 Services Not Requiring a Primary Care Provider (PCP) Referral

The following services do not require a referral by the PCP; however, they must be a covered service under the participant's benefit plan. If the service is not on this list, it must have a referral:

- **Audiology Services:** Performed in the office of a certified audiologist. Audiology basic testing requires a physician's order not necessarily from the PCP.
- **Immunizations:** Immunizations do not require a referral when they do not require an office visit. Specialty physician/providers administering immunizations are asked to provide the participant's PCP with immunization records to assure continuity of care and avoid duplication of services.
- **Chiropractic Services:** Performed in the office, Medicaid will pay for a total of 24 manipulations during any calendar year for the treatment of misalignment of the spine (subluxation).
- **Dental Services:** Performed in the office, however, procedures performed in an inpatient-outpatient hospital setting or ambulatory surgical center setting may require a PA and does require a referral from the PCP. The referral should identify the facility and ancillary physicians/providers such as anesthesiologists, pathologists, radiologists, pre-operative exam by a physician, and lab work.
- **Emergency Department:** Services provided in an emergency department of a hospital.
- **Family Planning Services:** Provided by district health departments or other agencies providing counseling and supplies to prevent pregnancy.
- **Intermediate Care Facility (for Developmentally Disabled)/ Mentally Retarded (ICFs/MR) Services:** (**Note:** These services are only covered for Medicaid Enhanced Plan participants.)
- **Indian Health Clinic Services.**
- **Influenza Shots.**
- **Nursing Facility Services:** (**Note:** These services are only covered for Medicaid Enhanced Plan participants.)
- **Personal Care Services:** (**Note:** These services are only covered for Medicaid Enhanced Plan participants.)
- **Personal Care Services Case Management:** (**Note:** These services are only covered for Medicaid Enhanced Plan participants.)
- **Pharmacy Services:** For prescription drugs only.
- **Podiatry Services:** Performed in the office, however, procedures performed in an inpatient or outpatient hospital or ambulatory surgery center require a referral from the PCP for the facility and ancillary physicians/providers such as anesthesiologists, pathologists, radiologists, pre-operative exam by a physician, and lab work.
- **School District Services:** Includes all health related services provided by a school district under an Individual Education Plan (IEP).
- **Screening Mammography:** Limited to one per calendar year, for women age 40 or older.
- **Sexually Transmitted Disease Testing.**

- **Transportation Services.**
- **Vision Services:** Performed in the offices of ophthalmologists and optometrists, including eyeglasses; however, procedures performed in an inpatient or outpatient hospital or ambulatory surgery center require a referral from the PCP for the facility and ancillary physicians/providers such as anesthesiologists, pathologists, radiologists, pre-operative exam by a physician, and lab work.
- **Waiver Services for the Aged and Disabled/Traumatic Brain Injury:** (**Note:** These services are only covered for Medicaid Enhanced Plan participants.)